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Body Esteem Predicts Sexual Functioning and Satisfaction for Women Reporting Childhood Sexual Abuse

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Body Esteem Predicts Sexual Functioning and Satisfaction for Women Reporting Childhood Sexual Abuse

by

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Body Esteem Predicts Sexual Functioning and Satisfaction for Women Reporting Childhood Sexual Abuse

by

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Research supports a link between poor body esteem, depression, and sexual dysfunction among childhood sexual abuse (CSA) survivors. Though the interplay of these factors also impacts nonabused women, it is possible that the impact is differentially affects these populations. The present study examined the degree to which body esteem may act as psychological mechanism through which CSA impacts adult sexuality, while controlling for the effects of depression – a problem that affects many abuse survivors. Data were collected from 108 women, 73 of who reported CSA. Women with CSA reported poorer body esteem, lower sexual functioning, less sexual satisfaction, and higher depression than women without CSA. Multivariate regression analysis revealed that body esteem significantly predicted sexual functioning and sexual satisfaction and there were significant interactions between body esteem and abuse history, and among body esteem and marital status. Depressive symptom severity was not a moderator in the relationship between body esteem and sexual functioning-satisfaction. These findings suggest that

treatments for CSA survivors with sexual difficulties might benefit from addressing body esteem concerns.

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Introduction

Childhood sexual abuse (CSA) has been linked to deleterious sexual outcomes in later life. This link is notably robust for outcomes such as sexual dysfunction and sexual dissatisfaction. Research among community samples of CSA survivors report significantly lower scores on measures of sexual desire and arousal as well as lower overall scores of sexual dysfunction and intimacy problems than nonabused women (Jackson, Calhoun, Amick, & Maddever, 1990; for a review see Polusny & Follette, 1995). Approximately 65% to 85% of CSA survivors reported sexual difficulties (Gorcey, Santiago, & McCall-Perez, 1986; Jackson, Calhoun, Amick, & Maddever, 1990; Jehu, 1988). The sexual functioning (e.g., sexual desire and arousal, orgasm ability) of undergraduate women reporting histories of CSA is comparable to women who have not experienced sexual abuse (Leonard & Follette, 2002; Rellini & Meston, 2007; Rind, Tromovitch, & Bauserman, 1998), but experience significantly greater sexual dissatisfaction and personal distress about their sexual concerns (Bartoi & Kinder, 1998 and Rellini & Meston, 2007, respectively). Prevalence studies also indicate higher rates of sexual difficulties among women with versus without CSA histories. Stein and colleagues (1988) reported 20% of women with a history of CSA experienced decreased sexual interest, sexual pleasure, and/or a fear of sex over the past 6 months, and Laumann et al. (1994) reported more than 1/3 of US women with a history of CSA experienced a lack of interest or pleasure in sex during the past year. There is evidence that the majority of women with a history of CSA who seek treatment for sexual problems meet clinical diagnostic criteria for sexual dysfunction (e.g, Jehu, 1988; Sarwer & Durlak, 1996).

While the relationship between a history of CSA and sexual dysfunction is well established, little is known about the mechanisms through which early abuse impacts sexual functioning and satisfaction. A small body of research has identified specific physiological factors that may be implicated in this relationship, including disruptions in sympathetic nervous system resting activity among CSA survivors (Rellini & Meston, 2006), and impairments to the hypothalamic-pituitary-adrenal axis also noted among abuse survivors (Bremner, Krystal, Southwick, & Charney, 1996; Yehuda, 2003). Psychological factors most commonly discussed in the relation between CSA and adult sexual functioning include sexual self-schemas and negative affect. Sexual self-schemas are cognitive generalizations about sexual aspects of one's self that have been influenced by past experiences, impact and guide current behavior and attitudes about sexuality (Andersen & Cyranowski, 1994). Women with positive sexual self-schemas may view themselves as emotionally romantic or passionate and are more open to sexual experiences. In contrast, women with negative sexual self-schemas tend to view themselves as sexually cold and unresponsive, display inhibited sexual behavior, and hold conservative view of sexuality. Sexual self-schemas differ between sexually abused and nonabused women such that women with a history of CSA view themselves as less romantic and passionate than non-abused women (Meston, Rellini, & Heiman, 2006). Recent evidence points to a potential meditational effect of sexual self-schemas on sexual function and satisfaction among sexually abused women (Rellini & Meston, 2009). With regards to affective differences between abused and nonabused women, studies have shown that CSA survivors are more likely to pair sexual words with negative affect than

are women without abuse histories (Meston & Heiman, 2000), and to more frequently endorse negative emotions regarding sex such as sexual guilt, poor sexual self-esteem, and sexual anxiety (e.g., Browne & Finkelhor, 1986; Gorcey, Santiago, & McCall-Perez, 1986; Walser & Kern, 1996). Among undergraduate women, reports of negative attitudes towards sex and less sexual assertiveness are significantly greater for women with a history of CSA than for women without a history of CSA (Johnsen & Harlow, 1996). One particular study found that anhedonia, the inability to experience pleasure from activities, rather than negative affect was the primary driving force in later adjustment for women with a history of CSA (Jackson, Calhoun, Amick, Maddever, & Habif, 1990). Body image, or body esteem as it is also referred to, is a psychological construct related to both sexual schemas and affect regarding sex. Donaghue (2009) found that positive sexual self-schema mediated the relationship between body esteem and positive affect, such that body esteem aids one's self-view as a sexual being and results in endorsing more positive feelings. Another study found a significant relationship between positive sexual self-schema and greater perceived facial and bodily attractiveness (Wiederman & Hurst, 1997).

Body image is also related to sexual functioning and satisfaction in women. Specifically, negative body image has been linked to lower sexual efficacy, sexual unassertiveness, and sexual avoidance (Lowery et al., 2005; Wiederman, 2000; Yamamiya, Cash, & Thompson, 2006). The link between negative body image and sexual outcomes has been explained in the aforementioned studies as a context-specific expression of body image concern. A woman with poor body image may experience an

increase of negative body-related thoughts when in a partnered sexual situation. Results from a study examining cognitive distractions during sexual activity indicated that negative body image significantly predicted appearance-based distracting thoughts during sex (Meana & Nunnink, 2006). Due to the influence of increased body-related concerns, a woman's behavior may be adjusted (less sexually assertive and avoidant) to accommodate her lack of body esteem. Alternatively, positive body image has been associated with greater frequency of sexual activity, adventure, optimism, and functioning (Ackard, Kearney-Cooke, & Peterson, 2000; Davison, Bell, LaChina, Davis, & Holden, 2008; Faith & Schare, 1993; Koch, Mansfield, Thurau, & Carey, 2005).

Three studies have found women with a history of CSA have poorer body images than nonabused women (Eubanks, Kenkel, & Gardner, 2006; Jackson et al., 1990; Wenniger & Heiman, 1998), and one study found that both physical and sexual abuse histories were related to poor body image in women, with physical abuse having a more deleterious impact (Treuer, Koperdák, Rózsa, & Füredi, 2005).

To date, studies examining the degree to which body image serves as a link between CSA and adult psychological well-being have focused primarily on eating disorder symptomatology. Smolak and Murnen (2002) conducted a meta-analysis of studies that examined the relationship between eating disorders and CSA. Findings revealed a small, yet significant positive relationship between CSA and eating disorders/problems ($r = 0.18$; Smolak & Murnen, 2002). The literature suggests that disordered eating is a coping mechanism for survivors of CSA who may not have developed appropriate ways of dealing with the distress and possible psychopathology,

such as depression or anxiety, that ensued post-abuse. Furthermore, there is robust evidence for body image as a key factor in the development of eating disorders (Stice & Shaw, 2002). In fact, body image disturbance is a diagnostic criteria for both anorexia nervosa and bulimia (DSM-IV-TR, 2000). Correlations between body image and disordered eating behavior range from moderate to strong, 0.39 to 0.56 (e.g., Jung & Forbes, 2006; Lokken, Worthy, & Trautmann, 2004). Specifically, the Body Esteem Scale (Franzoi & Shields, 1984) used in the current study has strong association with eating disorder measures (r = .61) as reported by Reddy and Crowther (2007). In addition, a meta-analysis revealed that women suffering from diagnosed bulimia and anorexia have significantly greater body dissatisfaction than healthy, non-afflicted women (Cash & Deagle, 1997).

As reviewed above, research supports links between CSA, poor body image, sexual dysfunction and dissatisfaction. The current study examined a potential role of body image in the link between CSA and adult sexual dysfunction in a community sample of women. It was hypothesized that body image plays a greater role in the prediction of sexual functioning and satisfaction for women with a history of childhood sexual abuse than for women without childhood abuse histories.

Method

Participants

Participants (N = 108, age range = 18 to 64) with and without a history of childhood sexual abuse were recruited from the community via advertisements in local newspapers, online classified postings, and referrals from health care providers. The

advertisements explained that the study was recruiting women 1) with a history of childhood sexual abuse prior to the age of 16 and 2) without any experience of sexual abuse, and the study involved expressive writing and disclosure of the woman's sexual history and behavior. Potential participants were screened for eligibility and received information regarding component 1 of the study in a phone interview. Component 1 consisted of measurements of psychosocial and sexual functioning and physiological reactivity and also included expressive writing on several topics. Participants who reported CSA *and* current sexual difficulties were invited to participate in component 2 of the study, a writing intervention aimed at addressing the sexual difficulties. Women were required to be at least 18 years of age and sexually active in the past four weeks. Women who experienced a traumatic event in the previous three months, been a victim of sexual abuse in the past two years, or had been diagnosed with a psychotic disorder in the previous six months were excluded from participation. Enrolled participants with a history of childhood sexual abuse reported at least one incident of a sexually abusive experience no less than 2 years prior. Sexual abuse was defined as unwanted sexual activity prior to age 16, and included one or more of the following acts: oral, anal, or vaginal intercourse, penetration of the vagina or anus using objects or digits, or genital touching or fondling. This group of participants was part of a larger treatment study for sexual dysfunction in survivors of childhood sexual abuse. For the purpose of the current study, participants who did not report incidents of sexual or physical abuse in childhood and no unwanted sexual experiences in adulthood were established as a comparison group (NSA). The NSA group participants were recruited in the same fashion as the CSA

group, via flyers and online advertisements without the study eligibility criteria of sexual abuse, and only participated in the initial visit. The nonabused women's demographic information was similar to nonabused women in other laboratory studies conducted in the same geographical region (Rellini & Meston, 2007).

Procedure

Questionnaire data were collected in the initial assessment session of the treatment study, prior to the treatment intervention. Both the NCSA group (n = 35) and the CSA group (n = 73) answered demographic questions about their age, ethnicity, level of education completed, and relationship status (See Table 1). Afterward, the participants completed measures assessing sexual functioning and satisfaction, body esteem, and depressive symptom severity.

Measures

Sexual Satisfaction. The Sexual Satisfaction Scale for Women (SSS-W) is a 30-item questionnaire that asks participants to rate their level of agreement with a series of statements on a 5-point Likert scale (Meston & Trapnell, 2005). Scores range from 0 to 130, with higher scores indicating greater levels of satisfaction. The SSS-W assesses five separate domains of sexual satisfaction supported by factor analyses: ease and comfort discussing sexual and emotional issues (communication), compatibility between partners in terms of sexual beliefs, preferences, desires, and attraction (compatibility), contentment with emotional and sexual aspects of the relationship (contentment), personal distress concerning sexual problems (personal concern, reverse-coded), and distress regarding the impact of their sexual problems on their partner and relationship at

large (interpersonal concern, reverse-coded). In a combined sample of women with and without sexual dysfunction, internal consistency coefficients for each domain were in the acceptable range (Cronbach's alpha ≥ .72). The current study found a similar alpha at .78.

Sexual Functioning. The Female Sexual Functioning Index (FSFI) is a 19-item questionnaire that is subdivided into 6 domains supported by factor analysis: desire (2 items), arousal (4 items), lubrication (4 items), orgasm (3 items), satisfaction (3 items), and pain (3 items). Each item is rated on a 5-point Likert scale where higher scores indicate greater sexual functioning (e.g., 1=*Very low or none at all* to 5=*Very high*). The questionnaire has been shown to discriminate between sexually healthy women and women diagnosed with female sexual arousal disorder (Rosen et al., 2000), and with female orgasm disorder (Meston, 2003). The FSFI has demonstrated good internal reliability (r = 0.89 - 0.97), and test-retest reliability (α = 0.79 - 0.88). A Cronbach's alpha of .91 was found for the current study's FSFI measure.

Body Image. The Body Esteem Scale (BES) is a 35-item instrument that measures esteem in relation to body parts and functions (Franzoi & Shields, 1984). Participants are asked to rate the degree to which they feel positive or negative about each on a 5-point Likert scale. A high score is indicative of greater body esteem. The Body Esteem Scale is composed of three subscales. The weight concern subscale is comprised of body parts that can be altered by exercise and that are generally considered to be under public scrutiny (e.g, thighs, appearance of stomach, weight). The physical condition subscale contains items relating to physical qualities that are generally not under public scrutiny (e.g., physical stamina, physical coordination). The sexual attractiveness subscale

contains items that cannot be altered by exercise and are often associated with physical attractiveness (e.g., breasts, face). Overall body esteem is calculated as the cumulative score for all three subscales in this study. The Body Esteem Scale has been shown to be internally consistent (Cronbach's alpha ≥ .78) and reliable over a 3-month period ($r \geq$ .75).

Depressive Symptom Severity. The Beck Depression Inventory (BDI) is a 21-item self-report questionnaire designed to measure depressive symptoms (Beck, Rush, Shaw, & Emery, 1979). The BDI was selected as a covariate in the current study due to the higher rate of depression among individuals who experience traumatic events. Each item consists of four statements, and participants are asked to select the statement that best describes their behavior or mood (e.g., "My appetite is no worse than usual"). In their review, Beck and colleagues (1988) stated that scores of 10-18 indicate mild-moderate depression; scores of 19-29 indicate moderate-severe depression, and scores of 30-63 indicate severe depression. Good internal consistency for a nonpsychiatric population (mean coefficient alpha = .81) has been found (Beck, Steer, & Garbin, 1988).

Results

Statistical Analysis

Initial statistical analyses were conducted among systematic variables (age, education, race/ethnicity, relationship status, and sexual orientation) and variables of interest (sexual satisfaction, sexual functioning, body esteem, and depression) across the abuse groups by the use of Independent Samples *t*-tests and Mann-Whitney *U* tests. Pearson Product-Moment Correlations identified significant relationships among the

independent and dependent variables. Considering the systematic group differences, positive correlations between independent variables, and the significant association between the two dependent variables, a multivariate regression model was selected. In this model, body esteem and abuse type were entered as independent predictors of the combination of sexual satisfaction and sexual functioning, while controlling for marital status and depressive symptom severity. The hypothesis that, compared to women without CSA, women with a history of CSA, with low body esteem will have poorer adult sexual satisfaction and functioning, was tested as an interaction between body esteem and abuse status in the model.

Participant Characteristics

Among demographic variables, relationship status and education level emerged as significantly different between the CSA and NCSA groups (*Mann-Whitney test,* $U_{relatioship} = 732$, $p < .001$, $U_{\text{education}} = 980$, $p < .05$). The percentage of married women in the CSA group (32.9%) was significantly greater than the NCSA group (8.6%). Also, the NCSA group contained a significantly greater number of women who were single, but currently dating (34.3%) than in the CSA group (5.5%). There were no significant differences in age, race/ethnicity distribution, or sexual orientation (See Table 1).

Sexual abuse was primarily defined as unwanted sexual contact, with the distinction between childhood and adult sexual abuse being prior to the age of 16 and "[as] an adult". According to prevalence data among the general population, approximately 15 – 25% of women experience adult sexual assault and/or rape (Messman-Moore & Long, 2000). As expected, 19% (14/73) of the women reporting

CSA also reported adult sexual abuse (ASA). However, 11 participants were excluded due to incomplete questionnaire data. ASA as a separate comparison group was not possible due to the relatively small sample number. Additionally, the CSA and CSA + ASA groups yielded similar sexual satisfaction and functioning scores as did the NCSA and NCSA + ASA groups (See Table 2).

The scores for the sexuality and body esteem variables were significantly lower for the CSA group: sexual satisfaction ($t(108) = 4.1$, $p < .001$), sexual functioning ($t(108) = 4.8$, $p < .01$), and body esteem ($t(108) = 3.5$, $p < .01$), as presented in Table 3. Specifically, the CSA group's full-scale scores for sexual satisfaction, sexual functioning, and body esteem were almost one standard deviation below scores for the NCSA group. Though the two group sizes were not equal (CSA $n = 73$, NCSA $n = 35$), the analyses were powered to an appropriate level and ranged from 0.80 to 0.82. The effect size was 0.45 for the group difference in sexual functioning and 0.46 for sexual satisfaction. The mean scores for the covariate, depressive symptom severity, were also significantly different ($t(165) = 5.4$, $p < .001$) such that the CSA group reported a greater degree of depression (i.e., clinically significant moderate depression). However, individual depressive symptom severity scores were highly variable in this group, ranging from 0 (no depressive symptoms) to 49 (severe depression).

Correlational Analysis

Pearson Product-Moment Correlations were computed for the variables under examination (Table 4). The CSA group's body esteem total scores were found to be correlated with three domains of FSFI sexual functioning: sexual desire, sexual arousal,

and lubrication (r = .35 to .41, p < .001). There was a marginally significant relationship between sexual pain and body esteem, (r = .21, p < .06). The orgasm and FSFI satisfaction domains were not correlated with body esteem. The NCSA group's body esteem total scores were not correlated with any of the sexual functioning domains (r = .07 to .24, p > .05).

Body esteem and SSS-W measures of sexual satisfaction correlations revealed that the relational concern domain was significantly related to overall body esteem for both the CSA and NSA groups (r = .35 and .29 respectively, p < .05). For the CSA group, the contentment domain (r = .38, p < .001) and overall sexual satisfaction (r = .31, p < .01) were significantly correlated with body esteem. The communication domain (r = .32, p < .05) was also significantly related to body esteem for the NSA group. Depressive symptom severity was significantly associated with the body esteem scores of the NCSA group (r = -.36 to -.52, p < .05), but not for the CSA group.

Multivariate Linear Regression Analysis

In order to determine the predictive value of body esteem on sexual functioning and sexual satisfaction, a multivariate linear regression was performed with sexual functioning and sexual satisfaction as the dependent variables and body esteem as the predictor variable. Given the noted relationship between depression symptom severity and body esteem for the NCSA group, it was added to the multivariate model as a covariate, and thus the variability associated with depression was held constant by its inclusion. The standard assumptions for conducting multiple regression analyses were

met (i.e., normality, homeoscedasticity). Table 5 presents the regression coefficients for the multivariate model and accompanying univariate results.

The model confirmed our hypothesis that body esteem and CSA history interact to significantly impact the combination of sexual satisfaction and functioning ($T^2 = 1.94$, $p < .01$), while remaining to have independent main effects. Additionally, the interaction between body esteem and marital status was significant ($T^2 = 3.18$, $p < .001$). Univariate analysis results indicated that only body esteem and abuse type were significant predictors for sexual satisfaction and for sexual functioning; no interactions were significant.

Discussion

Body image has been linked to sexuality among women without a history of abuse in numerous studies; only a handful of studies have examined this link among women with a history of childhood sexual abuse (CSA). The current study adds to the literature by examining the effects of body image on sexual functioning and satisfaction as a mechanism through which CSA impacts later adult sexuality. Consistent with previous findings, body esteem and sexual functioning were significantly lower and depressive symptoms were greater among women with CSA histories compared to women without CSA. Additionally, body esteem and the presence of a CSA history significantly interact when predicting sexual functioning and satisfaction, thus providing evidence for the hypothesis. Specifically, less body esteem compared to the NCSA group and experiencing CSA yielded poorer sexual functioning and satisfaction. A second

interaction between body esteem and marital status indicated that marriage may act in some way to facilitate a greater quality of sexual life.

The finding that body esteem was substantially poorer among women with a history of CSA versus women without CSA is consistent with past findings. Eubanks and colleagues (2006) found that compared to non-abused women, women with CSA had lower body esteem and greater body shape distortion such that they were unable to correctly rate the degree of distortion in altered photographs of themselves relative to their actual body shape. Wenniger and Heiman (1998) also found group differences in body esteem, especially for body parts associated with sexual attractiveness (e.g., breasts, face) among CSA survivors. Less esteem for body parts that are associated with attractiveness most likely impacts how a woman experiences sexual events. Jackson and colleagues (1990) demonstrated a relationship between body image and sexual functioning among young women who have experienced *intrafamilial* CSA. These women reported poorer body image and less sexual functioning than their non-abused counterparts.

Low body esteem in adulthood are associated with and may result in sexual problems such as diminished sexual desire and greater sexual dissatisfaction. Though this causal link has not been established, the current findings and other correlational data support this speculation (Jackson et al., 1990; Wenninger & Heiman, 1998). Of note, a few studies have found that experiencing sexual assault in adulthood does not appear to negatively impact women's body esteem (e.g., Kulkoski & Kilian, 1997). This highlights

a possibility of adult body esteem to be negatively impacted by sexual abuse that occurs in childhood.

In addition to noting body esteem differences between women with and without a history of CSA, the current study provided evidence that body esteem uniquely influences sexual functioning and satisfaction and that this relationship becomes differentially impacted by the addition of CSA experience. This finding suggests that poor body esteem may result from early sexually abusive experiences and may be particularly detrimental to later sexual functioning. At this point, we could speculate whether a difference arises from poor self-esteem stemming from CSA or from other life experiences. Though the correlational nature of the present study does not allow for assumptions of causality, the Traumagenic Dynamics Model of Child Sexual Abuse (Finkelhor & Browne, 1985) identifies issues regarding discomfort and unwanted attention towards the CSA victim's body leading to the production of negative body image which she may carry through to her adult sociosexual life.

The unexpected finding that marital status interacts with body esteem to predict a more positive sexual outcome provides some insight into the facilitative effects of being in a committed relationship - in this study, a marital relationship. The status of being married is not the facilitative factor, but rather it is the quality of the marriage and the socioemotional support that the woman receives (Fincham, 1998). Participating in a romantic relationship has been associated with less body dissatisfaction (Forbes, Jobe, & Richardson, 2006). The authors speculate that this link may perhaps be a result of women engaging in positive behaviors that maintain the relationship at an acceptable level of

quality. Women's partners may also provide positive, corrective feedback as opposed to reinforcing her negative body comments (Pole, Crowther, & Schell, 2004). In this respect, single women may not receive as many feedback opportunities for their body esteem.

Depression among women with a history of CSA compared with NCSA controls is consistently greater across studies (e.g., Browne & Finkelhor, 1988). In the present study, depressive symptoms were greater than reported in previous related studies (e.g., current study BDI scores of 20.5 versus 11.2 to 14.0; Jackson et al., 1990, Wenninger & Heiman, 1998, respectively). One selection factor that may account for the greater severity of depressive symptoms among women in the current study is that the women with CSA were recruited to participate in a treatment intervention study that required some level of distress over sexual functioning. With as many as 86% of the CSA group experiencing clinically significant depression, it is possible that, to some degree, depression was amplified by the women's poor sexual functioning and sexual dissatisfaction. Indeed, studies have consistently found a lack of interest and decreased frequency of sexual activity and increased sexual problems such as lubrication and arousal difficulties among depressed women (for review, see Dobkin, Leiblum, Rosen, Menza, & Marin, 2006). In the study's analyses, depressive symptom severity was not a significant predictor of sexual functioning and satisfaction, but was highly negatively correlated with body esteem for the NCSA group only. The relationship between depression and adult sexual functioning may be defined as a clear linear association when the interactive effects of sexual abuse are not present.

A few limitations should be considered when interpreting the current findings. First, the CSA group was larger than the nonabused group, but power analysis indicated that the statistical comparisons made were appropriate. CSA survivors were recruited based on their self-reported experience of sexual difficulty and knew of the possibility of having access to psychological therapy. The level of distress motivating treatment-seeking behavior may be greater for this sample than for women not experiencing distress or concern regarding their sexual lives. Consequently, the findings may not be generalizable to women who do not experience high levels of distress about their sexual lives or may be too embarrassed or ashamed of their abuse to participate in such a study. Also, body esteem was assessed in the laboratory as a measure of overall body part satisfaction regardless of context. Although this variable provided insightful data on the effects of general body image, contextual body image such as body esteem during sexual activity with a partner remains an unexplored area of examination. It may be that in real life sexual scenarios, CSA survivors experience comparable body esteem during sexual activity as do women without abuse histories or, more likely, they experience even more negative body image than in a laboratory scenario that does not involve partner evaluation.

There is a paucity of empirical evidence for the effectiveness of sexual dysfunction interventions among survivors of CSA (for a review see Leonard & Follette, 2002). Two therapies developed for CSA victims include emotionally focused couples therapy (Greenberg & Johnson, 1987), which is interpersonally based, and acceptance and commitment therapy to address sexual problems (Follette & Pistorello, 1995), a

psychotherapeutic treatment that emphasizes the achievement of psychological flexibility though mindfulness, acceptance of the distressing situation, and either changing or persisting through the situation in keeping with one's values (Hayes, Strosahl, Bunting, Twohig & Wilson, 2005). It is well accepted that depression is an important outcome in CSA therapies as rates of depression are much higher among this population (Martsolf & Draucker, 2005). The finding that body image plays a significant role in sexual functioning and satisfaction independent of depression among women with a history of CSA points to its importance as a factor, in addition to depression, to be addressed in treatment.

In conclusion, body esteem differentially impacts sexual outcomes among women with and without a history of CSA. In the development of body image in childhood, early sexualization may lead to negative cognitions and feelings associated with one's body and particularly with one's sexual self. Body esteem may be considered as a mechanism through which sexual difficulties and dissatisfaction in adulthood may develop for this population. Taking into consideration the effects of depression, CSA survivors overall experienced more symptoms, though depression played a greater role in sexual functioning and satisfaction for the nonabused women.

Table 1. *Participant Characteristics*

	CSA (n = 73)	NCSA (n = 35)	
	Mean (SD)	**Mean (SD)**	***p* <**
Age	32.2 (9.6)	33.0 (13.2)	*ns*[1]
	% (*n*)	**% (*n*)**	
Education			.015[2]
Less than high school / GED	4.1 (3)	1.2 (1)	
Completed high school / GED	12.3 (9)	8.2 (7)	
Some college/college degree	74.0 (54)	74.1 (63)	
Advanced degree	9.6 (7)	16.5 (14)	
Data missing	-	-	
Race/Ethnicity			
White*	49.3 (36)	71.4 (25)	*ns*[2]
Hispanic/Latina	16.4 (12)	5.7 (2)	
Black*	11.0 (8)	11.0 (8)	
Mixed race*	6.8 (5)	2.9 (1)	
Asian or Pacific Islander	5.5 (4)	11.4 (4)	
American Indian or Alaskan Native	5.5 (4)	-	
Data missing	5.5 (4)	-	
Relationship Status			.000[2]
Single, not dating	9.6 (7)	17.1 (6)	
Single, dating	5.5 (4)	34.3 (12)	
In a committed relationship	52.1 (38)	40.0 (14)	
Married	32.9 (24)	8.6 (3)	
Data missing	-	-	
Sexual Orientation			*ns*[2]
Heterosexual	71.2 (52)	85.7 (30)	
Bisexual	23.3 (17)	11.4 (4)	
Homosexual	1.4 (1)	2.9 (1)	
Data missing	0.4 (3)	-	

Note. CSA = Women with a history of childhood sexual abuse, NCSA = Women without a history of childhood sexual abuse. *=not of Hispanic origin
1=T-test for group differences
2=Mann-Whitney test for group differences

Table 2. *Abuse Characteristics among Participants*

	n (%)	Sexual Satisfaction *M (SD)*	Sexual Functioning *M (SD)*	Childhood Physical Abuse[b] *M (SD)*	Childhood Physical Abuse[b] Score Range
CSA Group	73 (68)				
CSA only	70	84.3 (22.8)	22.1 (6.3)	6.0 (5.5)	0 – 20
CSA + ASA[a]	3	81.7 (28.4)	18.7 (11.7)	9.0 (10.1)	0 – 20
NCSA Group	35 (32)				
NCSA Only	30	105.7 (28.3)	26.9 (4.6)	2.1 (3.0)	0 – 11
NCSA + ASA[a]	5	110.0 (28.6)	28.7 (4.7)	1.8 (1.0)	1 – 3

Note. CSA = Childhood sexual abuse, NCSA = No childhood sexual abuse, ASA = Adult sexual abuse [a] =Traumatic History Questionnaire [b] = Physical abuse subscale of the Childhood Trauma Questionnaire. Higher score indicates greater severity of physical abuse. A score of 0 indicates no physical abus

Table 3. *Group Means for Multivariate Regression Model Variables*

	CSA (*n* = 73)	NCSA (*n* = 35)	
	Mean (SD)	**Mean (SD)**	***p-value*[e]**
Sexual Satisfaction[a]			4.1***
Contentment	14.6 (4.3)	17.5 (5.2)	
Communication	20.3 (5.8)	22.4 (5.7)	
Compatibility	18.9 (7.0)	23.1 (6.0)	
Relational Concern	15.7 (7.3)	22.3 (7.5)	
Personal Concern	14.6 (6.6)	20.1 (8.0)	
Total	84.2 (22.8)	106.3 (28.0)	
Sexual Functioning[b]			4.8**
Desire	3.8 (1.5)	4.3 (1.1)	
Arousal	3.5 (1.6)	4.7 (1.0)	
Lubrication	4.2 (1.7)	5.3 (0.9)	
Orgasm	3.1 (0.9)	3.5 (0.9)	
Satisfaction	3.1 (1.5)	4.2 (1.4)	
Pain	4.2 (1.9)	5.1 (1.7)	
Total	21.9 (6.5)	27.1 (4.6)	
Body Esteem Scale[c]			3.5**
Weight Concern	27.0 (9.2)	32.7 (9.6)	
Physical Condition	28.4 (6.5)	31.5 (7.4)	
Sexual Attractiveness	42.8 (8.7)	49.2 (6.9)	
Total	98.3 (20.9)	113.4 (20.9)	
Depressive Symptom Severity[d]	19.3 (10.4)	12.3 (10.5)	3.3**
Minimal Depression (<10)	4.1 %	50.8 %	
Minimal to Moderate (10-18)	24.7 %	31.1 %	
Moderate to Severe (19-29)	34.2 %	11.5 %	
Severe (>29)	17.8 %	6.6 %	

Note. CSA = Women with a history of childhood sexual abuse, NCSA = Women without a history of sexual abuse. [a] = SSS-W, [b] = FSFI, [c] = BES (Higher scores indicate greater satisfaction, functioning, and body esteem), [d] = BDI (Higher scores indicate worse depressive symptoms), [e] = Independent samples t-test between CSA and NCSA groups

** = $p < .01$

Table 4. *Intercorrelation Matrix for Body Esteem, Sexual Functioning, Sexual Satisfaction, and Control Variables*

	1	2	3	4	5	6	7	8	9
1. BES Weight Concern		.71***	.61***	.92***	.48**	.38*	-.52**	.28	-.09
2. BES Physical Condition	**.71*** **		.55**	.87***	.41*	.41*	-.36*	.41*	.10
3. BES Sexual Attractiveness	**.53*** **	**.58*** **		.81***	.46**	.34*	-.30	.44**	.25
4. BES Full Scale	**.88*** **	**.86*** **	**.83*** **		.52**	.43*	-.47**	.42*	.08
5. SSS-W	**.26***	**.29***	**.43*** **	**.38*** *		.82***	-.64***	.37*	-.01
6. FSFI	**.23***	**.28***	**.56*** **	**.43*** **	**.58*** **		-.54**	.30	.13
7. BDI	**-.12**	**-.07**	**-.12**	**-.13**	**-.32*** *	**-.31*** *		-.28	.11
8. Age	**-.04**	**-.02**	**-.002**	**-.01**	**-.17**	**-.04**	**-.007**		.06
9. CPA	**-.06**	**-.05**	**.006**	**-.04**	**-.16**	**-.11**	**.18**	**.11**	

Note. CSA group correlations are bolded. BES = Body esteem, SSS-W = Sexual satisfaction, FSFI = Sexual functioning, , BDI = Depressive Symptom Severity

* = $p < .05$, ** = $p < 0.01$, *** = $p < .001$

Table 5. *Multivariate Linear Regression Results for Sexual Functioning and Sexual Satisfaction*

Source	T^2	*df*	*F*	$p <$	η^2
Multivariate					
BES	17.37	120	3.04	.001	.90
Abuse Type	.47	2	5.17	.01	.32
Marital Status	.21	2	2.32	*ns*	.17
BES x Abuse Type	1.94	16	2.55	.01	.49
BES x Marital Status	3.18	12	5.56	.001	.61
Depression	.13	2	1.45	*ns*	.12
Sexual Satisfaction					
BES		60	2.32	.05	.86
Abuse Type		1	5.10	.05	.18
Marital Status		1	.17	*ns*	.01
BES x Abuse		8	2.29	*ns*	.44
BES x Marital Status		6	1.78	*ns*	.32
Depression		1	1.23	*ns*	.05
Sexual Functioning					
BES		60	2.04	.05	.84
Abuse Type		1	10.44	.01	.31
Marital Status		1	.89	*ns*	.04
BES x Abuse		8	1.89	*ns*	.40
BES x Marital Status		6	1.27	*ns*	.25
Depression		1	.01	*ns*	.00

Note. BES = Body esteem.

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